MDR: M4-02-4707-01

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-03-2714.M4

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $11,480.000 for dates of service, 06/25/01, 06/26/01, 06/27/01, 06/29/01, 07/02/01, 07/03/01, 07/05/01. The Requestor's representative has withdrawn date of service, 07/06/01 via telephone conversation and facsimile on 02/03/03.

   b. The request was received on 06/25/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Copies of EOBs showing Carrier partial payment for 97799 CP (the same CPT Code in dispute) for previous dates 06/04/01, 06/05/01, 06/11/01, 06/12/01, 06/13/01 and 06/14/01.
   e. Copies of Carrier preauthorization approval for "PAIN MANAGEMENT PROGRAM", dated 05/30/01 and 06/17/01
   f. Copy of a Benefit Dispute Agreement dated 06/16/00 stating, "The parties agree the compensable injury is limited to the left shoulder, left arm, left wrist and hand."
   g. Letter of CARF accreditation dated 06/29/01
   h. Medical Records
   i. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 09/24/02
   b. HCFA(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Medical Records
   e. Copies of Carrier preauthorization approval for "PAIN MANAGEMENT PROGRAM", dated 05/30/01 and 06/17/01

f. Copy of a Benefit Dispute Agreement dated 06/16/00 stating, "The parties agree the compensable injury is limited to the left shoulder, left arm, left wrist and hand."
g. Letter of CARF accreditation dated 06/29/01
h. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 09/05/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/10/02. The response from the insurance carrier was received in the Division on 09/24/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/14/02

"(Claimant) was originally referred to our pain management in May of 2001. An evaluation and a PPA was completed. The program was approved and (Claimant) attended 20 sessions, and the billing was submitted. We have received payments on several dates of service, however, 8 dates are still not paid and have been denied for any additional payment…. The guidelines are very specific regarding payment compensation and time frames as to receipt pf payment. (Carrier) has ignored these rules and are obviously in direct violation of these rules. The services were rendered and payment is due."

2. Respondent: Letter dated 09/24/02

"In this matter, the Self-Insured contends the treatments made the basis of this dispute were not directed at the compensable injury. Rather, the treatments appear to have been directed (at least in part) to the cervical region – which is not compensable. Per Commission Rule 134.600 (c), the carrier is not liable for pre-authorized treatments if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

In this instance, the Claimant executed a Benefit Dispute Agreement (TWCC-24), agreeing that his compensable injury is limited to the left upper extremity (shoulder, arm, wrist and hand.) No cervical injury is compensable, and any treatment directed at this area is non-reimbursable. Also, the Requestor appears to have billed $205 per hour for the pain management program. However, neither the Requestor's TWCC-60 nor the Requestor's Additional Information contains proper justification for billed costs. The

information provided by the Requestor contains no cost breakdowns at all; indeed, the information gives no cost-basis at all upon which the Requestor might base its bill. Per the Act, the Requestor is entitled only to those monies that are fair and reasonable. In order to demonstrate the reasonableness of its bills, the Requestor must provide evidence that the amounts charged achieve effective medical cost control, take into account payments made to others with an equivalent standard of living and consider the increased security of payment. TEX. LAB. CODE §413.011. The Requestor provides no such information."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 06/25/01, 06/26/01, 06/27/01, 06/29/01, 07/02/01, 07/03/01 and 07/05/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. The Requestor billed the Carrier $10,045.00 (49 hours @ $205.00/hr) for services rendered on the remaining dates in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $0.00 for services rendered on the remaining dates in dispute.

5. The Carrier's EOBs deny additional reimbursement as "R – EXTENT OF INJURY".

6. A Benefit Dispute Agreement dated 06/16/00 states, "The parties agree the compensable injury is limited to the left shoulder, left arm, left wrist and hand."

7. The Requestor has supplied a copy of Carrier's EOBs showing partial payment for the same CPT Code rendered on dates of service prior to these dates of service in dispute.

V. RATIONALE

Medical Review Division's rationale:

The Requestor has billed CPT code 97799-CP, which is a DOP (no MAR) per the MFG. The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR." CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

Medical documentation submitted indicates these charges are for a chronic pain program. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. The provider has submitted additional reimbursement data: four example EOBs for charges billed for a similar procedure. The carrier asserts that they have paid a fair and

reasonable reimbursement but have not submitted a methodology to support their reimbursement. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable.

Even though the denial was "R – Extent of Injury", a chronic pain program is a program which provides coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning, and decrease the dependence on the health care system…" The medical "Exercise Regime Progress Notes" indicate that the (L&R) hand, wrist, forearm, shoulder and neck were listed under "Subjective Pre APT Pain Level." However, the treatment was actually to the whole "person", which is what a chronic pain program should treat. It incorporates whole body exercise, group and individual therapy, etc. It is impossible to separate out "the neck" from the whole body approach.

In this case, the Requestor has provided Carrier EOBs showing a **partial** payment of $700.00 for each CPT Code 97799 CP billed at $1435.00 for services provided on 06/04/01, 06/05/01, 06/06/01, 06/11/01, 06/12/01, 06/13/01 and 06/14/01, dates **prior** to the dates in dispute. "Exercise Regime Progress Note" medical documentation submitted for the dates the Carrier made payment, indicate services were rendered to the same areas of the claimant's body as the dispute dates. Therefore, it is unclear why Carrier made partial payment for dates of service (dos) 06/04/01, 06/05/01, 06/06/01, 06/11/01, 06/12/01, 06/13/01 and 06/14/01, but denied payment for the above dos in dispute. Additionally, per TWCC's Compass (Dispute Resolution Information System), the Requestor has not filed any other disputes for reimbursement of services rendered to this claimant. As such, this supports the Requestor accepts the Carrier's **partial** payment of $700.00 ($100.00 x 7/hrs = $700.00) for each previous dos as fair and reasonable. Additional reimbursement of **$4,900.00** ($100.00 x 49/hrs billed = $4,900.00) is recommended.

The above Findings and Decision are hereby issued this 7th day of February 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$4,900.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 7th day of February 2003.

Carolyn Ollar
Supervisor - Medical Dispute Resolution Officer
Medical Review Division

CO/dt